STRATEGIC REVIEW OF CSO CORE FUNDED UNITS
STAKEHOLDER QUESTIONNAIRE

Response submitted by: CSO Public Engagement Group

As a lay group we cannot answer many of the questions listed above but would like to put forward a response from our perspective.
Having been involved in the lay reviews in Aberdeen for both the HERU and HSRU units I can only assume that comments will apply to NMAHP-RU and SPHSU.
The core funding supplied to these units appears to draw them into the Scottish research field and helps them become involved in the wider research landscape nationally and globally. If the funding were removed completely it might lessen the profile of the units within the Scottish Research field. It is a fact that any business operating outwith the central belt can encounter difficulties of remoteness especially those from the North.
It is the contact with the CSO, in whatever form, that aids in raising the units' profile. Conversations with people in other parts of the Health Service and research field who encounter the same problems of distance from the Central belt.
It also appears that the units are very successful at what they do.

STRATEGIC REVIEW OF CSO CORE FUNDED UNITS
STAKEHOLDER QUESTIONNAIRE

Response submitted by: ***Scottish Government Office of the Chief Social Work Adviser***

1. How would you change the current arrangements and why?
   Note please that comments are based on limited knowledge of the outputs of the CSO Units and the current arrangements for review, funding and agreement of programmes. We are not aware of having been previously involved in these processes.

   - *Change to develop more flexibility in allocation of resources to increase ability to redirect funding to respond to changing priorities.*
   - *Funding that allows capacity for delivery of shorter term policy-relevant outputs.*
   - *Policy priorities have changed significantly with the integration of health and social care and it could be useful to consider how the approach to funding could be changed to support research of more relevance to integrated arrangements.*
   - *Despite the title for the funding, [*CSO is responsible for supporting applied research in the health and care system in Scotland] *the units do not seem to have a profile in social services and appear to be largely health research units and seen as such. It is not clear to what extent engagement takes place with social services policy teams, delivery organisations or relevant social services academics in considering the strategic direction of the work, in considering the outputs or in reviewing the units themselves. We note that the membership of this review is heavily health oriented. If this funding is to support applied research in health and care, perhaps the involvement of key social care stakeholders could be strengthened.*

2. What outputs have you seen or used from CSO funded units in the past and what health research outputs would you like to see from the units?
   - *Not aware of having seen or used any outputs from CSO funded units and would like to see more in the way of research outputs relevant to social care, social services workforce, social care economics and integrated service delivery.*

3. What sort of engagement would you wish to have with CSO funded units?
   - *Opportunity to comment on priority areas for establishing units*
   - *Opportunity to comment on strategic objectives, high level research priorities,*
   - *Would wish to see engagement of social services stakeholders in developing the above.*
   - *Opportunity to request short-turnaround reports on specific topics where they have relevant expertise – similar to arrangements for Centres of Expertise funded by RESAS.*
   - *Would like to receive notice of relevant research when this is being developed/considered/commenced and of relevant outputs when produced.*

4. What do you consider should be the principal objectives, activities and responsibilities of CSO core funded units, and what should be the advantages, added value and outcomes from this funding?
   General comments:
   - *As this is direct government funding, rather than funding via a research council, the funding should aim to generate outputs of more practical application, in particular outputs of value to policy development, implementation and evaluation.*
   - *Additional advantages/added value of this funding approach should be to build expertise in policy understanding, policy development processes within the academic community and greater understanding of the value of research and academic input in the policy community. The funding could help to develop a stronger bridge between government policy and academia.*
   - *The funding should seek to fill gaps in funding priorities left by the Research Councils and other funding bodies, in particular it should seek to prioritise the value of outputs in practical application and policy relevance rather than the standard outcome measures of research excellence that are central to Research Council priorities (notwithstanding the use of impact measures in the REF and approaches that seek to look at impact in Research Council evaluation).*
   - *Funding should allow (or potentially require) researchers to participate in shorter term, policy-responsive work in addition to more conventional research projects that deliver more academic outputs.*

   Specific comments:
   - *Given the stage of health and social care integration, a number of areas of work could be reoriented to make them more relevant, in particular, investment in health economics research should be reoriented to include consideration of the economics of social care and of integrated health and social care – this needs to move beyond isolated PhD projects and could be used as an opportunity to develop a centre of expertise in this area and deliver outputs that can directly inform policy.*
   - *Similar comments could be made for the work on health workforce and the work at NMAHP-RU which is also largely health-focused and NHS-based.*
   - *In general it could be useful to assess each centre on to what extent it addresses and/or considers the priority needs of Scotland's integrated health and social care system.*

5. Do the current arrangements support both research excellence and the production of research that is responsive to pressing health policy and practice needs or are there disadvantages of this and would different arrangements or alternative models (such as the models set out in the review panel's terms of reference) be more appropriate?
   - *It is very difficult for academics to deliver research outputs that are both excellent by standard research excellence output measures and that are also responsive to pressing health (and social care) policy and practice needs – i.e that deliver outputs of practical/policy value. Neither the timescales on which academic research tends to operate, nor the kind of questions that are valued tend to chime with policy /practice interests.*

- *I am not sure this is a realistic combination of requirements for a funding stream – some kind of trade-off needs to be accepted.*
- *Models that might work better are the policy research unit model outlined in the Reviews ToR (though no direct experience of this) and some features of the Centre of Expertise model used by RESAS in SG – these vary in their set-up and mode of operation.*

6. What criteria and processes should CSO apply to considerations about continuing, discontinuing and establishing core funded units (or alternative models of research support), including the exit strategy if funding is discontinued?
    - *May be best to have an approach that builds in sunsetting to core units, similar to the approach used by MRC for their Centre's – e.g. anticipated life-span of 10-15 years with an expectation that funding will cease after that time.*

    Criteria:
    Establishing –
    - *prioritisation of areas of work through horizon-scanning by appropriate mixed groups of experts/academics/policy makers/practitioners,*
    - *policy input and evidence from recent years of the main focus of policy-commissioned research and consultancy.*

    Continuing:
    - *Use of outputs from above process to assess continuing need.*
    - *Impact evaluation that looks for example at indicators such as:*
        - *Number and extent of contacts with policy teams and practitioners and trends over that period.*
        - *Evaluation of impact of outputs over last five years.*

    Discontinuing:
    - *Use of outputs from above to identify areas that are falling down the priority list, and/or where trends suggest a drop-off in policy/practitioner engagement, and results of impact evaluation.*
    - *Automatic sunsetting after a maximum number of years (e.g. 10-15).*

Thanks very much for consulting for us on this. The directorate at DHSC and NIHR (as far as we are able to judge from annual reports submitted by NIHR infrastructure) have v little interaction with your core units. What little info we have is below. We'd be happy to talk though the pros and cons of approaches NIHR has taken when you move to options appraisal.

Health Economics Research Unit (HERU) at the University of Aberdeen

This is one of the few organisations that do labour market economics in health. So useful from that perspective, not least as we know there is a growing need for workforce research.
They've provided panel members and peer reviewers for NIHR.

Health Services Research Unit (HSRU) at the University of Aberdeen

Has some overlap with HERU so useful from the workforce perspective.

Nursing Midwifery and Allied Health Professionals Research Unit (NMAHP-RU) at the University of Stirling and Glasgow Caledonian University

They have provided reviewers and panel members when dealing with nursing research issues in England.

Social and Public Health Sciences Unit (SPHSU) at the University of Glasgow

We're not aware of any interaction, but that doesn't mean there hasn't been with individual researchers.

CSO Units: Response to Strategic Overview of CSO Core-funded Units, Stakeholder Questionnaire , Glasgow Caledonian University

1. How would you change the current arrangements and why?

In part, the answers to this, and indeed, all of the questions posed depend on what the funders wish to achieve not only with respect to Units but also with the rest of the spend on infrastructure, response-mode funding and contributions to other UK programmes such as NIHR. In many respects, we would not wish to change the current arrangements because we feel very positive about them; the relationships with staff (from NMAHP-RU which we share with the University of Stirling), our partner university (Stirling) and CSO.

That said, the advantages of Units might relate to:

- Capacity building and creation of core groups and critical mass in important areas of research for the country.
- Relatedly, the fact that the Unit spend supports the non-medical aspects of that. That is seen as a plus by many and also, it could be argued, has enhanced Scotland's UK and international reputation for health economics, health services and public health research.
- Relatedly, the Units also have fostered a different approach to health economics, health services and public health research, one that, in some fields, has created excellent leadership around the whole of the UK for example.

Disadvantages relate to things like:

- Path dependency and how long any initial investment should continue.
- Whether Units can genuinely call themselves 'national'. This relates not only to which academics are involved in the Units but also the 'spaces' in which they operate (see below).
- Whether the Units have served notions of creating sustainable research workforces in some clinical (but non-medical) areas, like AHPs, and related to that, whether they contribute to furthering clinical academic careers in the context of there being sparse opportunities for such roles outside Medicine.

Alternative models (policy research units, schools or different types of MRC-type arrangements) are possible, but, in England, all of these types of arrangement are available, and funded, as is the case, to a lesser extent, in Scotland (e.g. in the area of public health).

Some sort of combination might be the way to go in Scotland, whereby units are at the hub of national networks of health economists and health services and public health researchers. Many clinical groups now operate on the basis of national or regional (in England, given population size) networks. This might then ensure genuine national coverage for such research. This might involve co-working across Units as a stipulation and also membership from Universities with strengths but who have no current Unit affiliations; and, likely would require some investment (from HEIs and CSO).

2. **What outputs have you seen or used from CSO funded units in the past and what health research outputs would you like to see from the units?**

   Methods-wise, there are lots of outputs that others have used – for example, in health economics, the alternative valuation frameworks (discrete choice analysis and willingness to pay) that emerged from the work of the Health Economics Research Unit. This Unit has contributed substantially to health economics leadership in Scotland, the UK and internationally and some of its outputs (e.g. based on its original health economics correspondence course) are famous and have been impactful.

   Outputs of others relate more to contributions to the evidence base on major areas of clinical and public health activity, as indicated by publications in top medical journals (both general and field) as well as other major outlets. These are significant contributions to health research, and are appropriate vehicles for dissemination, hence we do not propose any other types of research output (as per the question).

3. **What sort of engagement would you wish to have with CSO funded units?**

   Genuine collaborative research that:

   - takes place across the country, and perhaps through structures such as national networks.
   - reflects the changing nature of society (e.g. co-production, the role of Civil Society in health [and relatedly, more upstream holistic approaches], developing and evaluating genuine social innovation as opposed to that which is technology-based, important though that is, and the relevance of realistic medicine).

4. **What do you consider should be the principal objectives, activities and responsibilities of CSO core funded units, and what should be the advantages, added value and outcomes from this funding?**

   High quality research as assessed by research outputs and other REF-related factors (such as impact). Can we say that all areas are genuinely world-leading?

   Not so much 'fostering links' as creating substantial and long-standing, high-quality research networks across the country. Something more in-depth and substantial is required in this area as engagement with the wider academy, NHS, Third Sector and Civil Society is not universally strong.

   Developing methods is important, as staff should be developing their own areas of speciality as well as conducting high-quality service-type research. There can be a tension in resourcing between providing 'service' to research utilising tried-and-tested methods and developing methods to deal with increasing complexity or multiple perspectives.

   Making available a body of expertise is important, too, but this has to be more substantial also; again, through some sort of network approach. The same point applies to building

research capacity, i.e. is this capacity located geographically to greatest effect? If not, how can this be achieved beyond organising research meetings that do not always seem to be communicated to maximum effect and invite input from others in the same areas of work (but outside of Units).

In addition, are Units operating in important, contemporary spaces – ones in which major health challenges prevail or new issues have emerged which we have not been able to address. 'Spaces' might not necessarily be geographic, but could be. Some examples might be:

- Collaborative work in large parts of the country, either in terms of population density (Lanarkshire, Central Belt outside of Glasgow and Edinburgh, Tayside and Fife) or land mass (Highlands & Islands and Borders).
- Services, in particular to reflect the recent health and social care integration agenda. What types of new challenges does this bring? Can they be addressed by our current Unit configuration? How does Civil Society play into this? How does the vision for Realistic Medicine, and biomedicine industrial innovation (increased availability of diagnostic tests, medical devices, for example) impact these?
- Should other Government Directorates be contributing to Units which could perhaps foster and research more-holistic approaches to health improvement?

5. Do the current arrangements support both research excellence and the production of research that is responsive to pressing health policy and practice needs or are there disadvantages of this and would different arrangements or alternative models (such as the models set out in the review panel's terms of reference) be more appropriate?

Evidence from the Research Excellence Framework would indicate that Units have had a positive impact on policy and practice and, through doing so well in successive REF exercises, on the research reputation of various Universities involved.

Other indicators would point to areas where we might seek to be more ambitious for Scotland's health research. It could be argued that the largest issues facing society and the health & social care system, with respect to health, are persistent inequalities, management of long-term conditions and austerity (and the associated need to better manage scarce resources at local levels and in new integrated entities). Given the persistence of inequalities, do we need other approaches that may or may not exist in Units? Is that indicative of the need for a wider, more-inclusive approach or set of structures? Are we learning the lessons of ongoing austerity in terms of how better to manage claims on the health (and now social care) system in the context of whether we have a balance of care fit to meet the needs arising from long-term condition management? Hence we might need to drive greater research impact in these, traditionally less-well-researched areas (e.g. social care).

Are important areas of research represented? Indeed, are there existing groups or pockets of researchers currently not as well represented (at other Universities, or in existing host universities in areas like AHP or midwifery) whose existence could be even better exploited to the benefit of Units and the wider Scottish population by inclusion in

frameworks that might have the practical impact of fostering clinical academic careers in non-medical areas?

6. **What criteria and processes should CSO apply to considerations about continuing, discontinuing and establishing core funded units (or alternative models of research support), including the exit strategy if funding is discontinued?**

   Criteria could cover:

   - Standard outputs in terms of publications and grants (as a measure of quality as well as contribution).
   - Are they leading in their field as well as contributing to policy?
   - To what degree have they met original and other subsequent objectives laid down for them?
   - Are the Units able to leverage monies which could, partly, underpin long-term sustainability. With that, can they demonstrate how talent has been identified, invested in and succeeded through academic pathways and appointments (supported by host institutions) that can compete at an international level through the Units?
   - Whilst working to nationally set objectives, to be globally engaged, to what extent are the Units adapting to, adopting or somehow engaging with international initiatives such as the Sustainable Development Goals?
   - Are they (still) fit for purpose - e.g. from a funder perspective? Are they addressing major issues, such as management of long-term conditions, public health interventions and initiatives and management of austerity?
   - Are they genuinely 'national'? To what degree do they need to be? How might we develop indicators of that? Are we covering all of the necessary 'spaces'?
   - To what degree do they duplicate each other and similar strengths elsewhere?

Likely one for CSO funding overall is:

- To which extent does the overall funding system, including the Units, enable us to maximise 'capture' from other research funders such as NIHR and UKRI?

Response submitted by: Health and Social Care Analysis Division, Scottish Government

1. How would you change the current arrangements and why?

Our main engagement has traditionally been with HERU via our Deputy Director, being on the HERU advisory group, and the efforts that are made by the HERU Director and senior team to ensure that their work programme is relevant to the Scottish Government's key policy priorities. While we have worked with the other CSO-funded units they have not been proactive in contacting us to help shape their work programmes and it is unclear how prioritisation works. CSO does not directly involve HSCA in that process.

Across the Units we struggle to get much specific analysis that we can use in our work, or that of our policy divisions. We and/or our policy divisions often require relatively small pieces of analysis done relatively quickly that we have no internal capacity and/or expertise in. These typically relate to immediate policy need and are often difficult to identify in business planning cycles. Without a clear mechanism in which we can approach the CSO-funded units this work is typically commissioned out via open competition, or we seek capacity within NHS National Services Scotland. With the HERU leadership team, we previously tried to implement a couple of potential solutions. HERU employed an ex-SG economist for 1 day per week to do this type of work for us. We have also tried to ensure that we liaise with HERU on our own work programme so potential synergies and opportunities for joint working are identified. In addition, MRC/CSO SPHSU recently undertook the realistic medicine evaluability assessment on our behalf. We were required to make a case for a non-competitive action based on the Unit's particular expertise. It would be helpful to have further opportunities to draw on their expertise in evaluation planning without necessarily having to go down the route of an NCA.

We feel that given the considerable financial public investment in the Units a mechanism needs to be found in which we have timely access to the expertise within the Units. This could, for example, take the form of a call-off contract that enables us to 'buy' in a certain amount of input over the course of the year. We would also welcome a more direct role in helping to shape the strategic priorities of the Units, for example by being represented on governance groups as with HERU, or via more joined up working with CSO itself.

2. What outputs have you seen or used from CSO funded units in the past and what health research outputs would you like to see from the units?

Our main use of the outputs from the Units has tended to be HERU and CSO/MRC SPHSU. We have previously used some of HERU's published analysis to inform the evidence base for policy development, for example in the case of tobacco, alcohol and dietary/obesity policy. Currently we are engaging with HERU on a number of their projects on workforce as this is a high priority area for our division. Analysis by HERU has also contributed substantially to resource allocation work – through the NRAC committee and subsequently the TAGRA group. In each case, an academic from HERU has been a member of the group and has provided invaluable input, providing academic and technical rigour to the work and helping to quality assure the outputs in

this important area of our work. SPHSU has recently produced a set of evaluation options aligned to realistic medicine priorities taking account of potential resource constraints and we have had some engagement with them on Minimum Unit Pricing for Alcohol. At times we have been involved in the work of NMAPH.

On the whole, however, we have not used outputs of these Units to any great degree. We are aware of the significant programmes of work undertaken by these Units and part of the issue may not be so much around relevance but about timeliness and engagement. There appears to be limited knowledge exchange between academics and decision makers within government. Mechanisms could be developed to try to encourage the use of Unit outputs based on a realistic assessment of what policy makers require.

3. What sort of engagement would you wish to have with CSO funded units?

Our engagement with HERU is much stronger than with the other units because of the health economics link, and because our division has provided a senior economist to act as a member of the Unit Advisory group for HERU over the years. This has meant that we have had regular meetings with HERU (generally twice a year or so) where we update them on SG Health and Social Care key priorities, which enables them to focus their work programme on areas of most policy relevance.

Ideally, as the analytical team within Health and Social Care, we would have closer engagement with the other units too, but in practice we don't have the capacity or resource in our team to make regular contacts of this type.

Ideally I think academic units should take a more pro-active approach to making the links in to government analysts and policy teams, and see that as part of the day job. Certainly, where core funding has been provided, I think that should be a clear expectation.

4. What do you consider should be the principal objectives, activities and responsibilities of CSO core funded units, and what should be the advantages, added value and outcomes from this funding?

Rigour, objectivity and relevance should be core principles of the work of the Units. Tied to the comments above, we also feel there should be specific objectives and activities to reflect the fact that government is providing funding. Specifically relating to informing policy making and evaluation, these could be two-fold:

- objectives around the delivery of more applied and policy relevant analysis. This may not always require to be of the same standard as academic, peer-review publications but rather be timely, and communicated simply but persuasively. This would not be to the detriment to the unit's reputation for undertaking high quality analysis.

- objectives relating to closer, regular contact with government policy makers and analysts, and knowledge exchange activities.

We found value where a HERU academic became a member of one of our committees or working groups on a particular topic – specifically, in relation to resource allocation formula work (NRAC and TAGRA groups). This ensured continuous 2-way engagement, enables the academic colleague to see the full range of issues we are working with and to contribute on a number of levels as part of the ongoing work. We would welcome future opportunities to develop better knowledge transfer arrangements.

5. **Do the current arrangements support both research excellence and the production of research that is responsive to pressing health policy and practice needs or are there disadvantages of this and would different arrangements or alternative models (such as the models set out in the review panel's terms of reference) be more appropriate?**

The current arrangements have supported HERU to receive 5-star ratings and the staff are very highly regarded in their field. SPHSU also have a strong reputation for the quality of the work produced (we are less familiar with the other Units). However, as outlined above, it has not been easy to commission research that is responsive to pressing health policy or practice needs. We feel serious consideration should be given to how that may be addressed and have suggested a number of possible mechanisms.

6. **What criteria and processes should CSO apply to considerations about continuing, discontinuing and establishing core funded units (or alternative models of research support), including the exit strategy if funding is discontinued?**

As outlined above, criteria should include the extent to which research is directly used for evidencing policy development, monitoring or evaluation. We also feel capacity should be built in allow academics in core-funded units to directly work with Scottish Government analysts and policy makers on a number of key priority areas.

We do not feel well placed to comment on potential exit strategies.

Response from : Healthcare quality and improvement

1. How would you change the current arrangements and why?

   Awareness of the current arrangements was not high among staff and this limited identification of changes that might be made, other than the obvious suggestion about the need to improve awareness and engagement in respect of the work of the Units and their relevance/impact to policy development and implementation support.

2. What outputs have you seen or used from CSO funded units in the past and what health research outputs would you like to see from the units?

   As above, the level of awareness and use of outputs was generally low or nil.

3. What sort of engagement would you wish to have with CSO funded units?

Would welcome more to raise awareness of what they do and the services they can provide amongst those areas their work most closely relates to, including how it might be possible to

explore integration with existingly funded and established stakeholder engagement processes.

4. What do you consider should be the principal objectives, activities and responsibilities of CSO core funded units, and what should be the advantages, added value and outcomes from this funding?

   Clear alignment and integration with national performance outcomes and focus on ways in which scientific work can identify new knowledge with potential to impact on delivery of safe, effective and person-centred care and/or reliable delivery at scale of approaches derived from new knowledge – which may benefit from links with HIS and could also be linked with the forthcoming review of the Scottish Improvement Science Collaborating Centre.

5. Do the current arrangements support both research excellence and the production of research that is responsive to pressing health policy and practice needs or are there disadvantages of this and would different arrangements or alternative models (such as the models set out in the review panel's terms of reference) be more appropriate?

   Staff did not feel sufficiently engaged or informed to contribute, though would welcome the opportunity to do so.

6. What criteria and processes should CSO apply to considerations about continuing, discontinuing and establishing core funded units (or alternative models of research support), including the exit strategy if funding is discontinued?

   It was suggested that corporate procedures and best practice in commissioning/funding programmes may be useful in terms of including advance consideration of this and the

explicit incorporation of this into regular progress and impact review processes. Awareness raising work would be integrated with external stakeholder engagement reference/evaluation panels that include citizens whose lives may be impacted upon by the science outputs and work.

STRATEGIC REVIEW OF CSO CORE FUNDED UNITS
STAKEHOLDER QUESTIONNAIRE

Response submitted by: **Mental Health Directorate, SG**

1. How would you change the current arrangements and why?
   I would like a greater prioritisation of mental health research in keeping with its priority in Scottish Government and the relative burden of disease.

2. What outputs have you seen or used from CSO funded units in the past and what health research outputs would you like to see from the units?
   - The Distress Brief Intervention Programme is benefiting from NMAHP-RU Stirling University expertise.
   - The annual scottish mental health research network doesn't feature in your description below, but it runs an important and engaging annual meeting and a forum for me to go to about research questions.

3. What sort of engagement would you wish to have with CSO funded units?
   I personally interact fairly regularly with CSO but I would like more structured connection, beyond me, to relevant policy officials in the mental health directorate.

4. What do you consider should be the principal objectives, activities and responsibilities of CSO core funded units, and what should be the advantages, added value and outcomes from this funding?
   As above mental health needs prioritised in line with SG policy priority and relative to burden of disease. There has been historic underfunding and the public donate far less for mental health research compared to e.g. cancer or heart disease. Mental Health research is needed to ensure policy is aligned with evidence , is evaluated and provides clear outcomes that matter. In turn research needs to have impact and to do this it needs to consider the strategic environment.

5. Do the current arrangements support both research excellence and the production of research that is responsive to pressing health policy and practice needs or are there disadvantages of this and would different arrangements or alternative models (such as the models set out in the review panel's terms of reference) be more appropriate?
   There is a disconnect between policy and research – currently I am the only physical bridge in SG for mental health but this needs widened to other civil servants. CSO could connect more formally to colleges eg RCPsychiatry to help promote its function to promote high quality research.

6. What criteria and processes should CSO apply to considerations about continuing, discontinuing and establishing core funded units (or alternative models of research support), including the exit strategy if funding is discontinued?
   Must be aligned to relative policy priority and ideally balanced against relative burden of disease. It can't be too complicated or people won't understand.

STRATEGIC REVIEW OF CSO CORE FUNDED UNITS
STAKEHOLDER QUESTIONNAIRE

Response submitted by:
Public Health & Intelligence (PHI), NHS National Services Scotland

PHI is consisted of two organisations i.e. Information services Division (ISD) and Health Protection Scotland (HPS) within NHS National Services Scotland. These two organisations are going to be part of the Public Health Scotland (PHS) in 2020. We have contributed substantially in the development the final report of the Leadership for Public Health Research, Innovation and Applied Evidence (LPHRIAE) Commission contributing to the Scottish Public Health Reform programme to establish PHS. In submitting this response, we would expect that the CSO and the Review Panel should take into account of this report as well.

We are also aware that colleagues in Health Scotland have also submitted their response to this questionnaire. We very much endorse their views to strengthen research in Scotland. Health Scotland is going to part of PHS as well.

1. How would you change the current arrangements and why?
   [insert response to this questions here]
   See under 5 – but would build and enhance on current arrangements through regular communication and linking more formally while establishing Public Health Scotland (PHS). It also depends on the role of PHS going to play in the research arena e.g. commission, co-ordinate and participating in research

2. What outputs have you seen or used from CSO funded units in the past and what health research outputs would you like to see from the units?
   [insert response to this questions here]
   - HSRU – trials in dental clinical interventions with Dundee are informing guidance and changing clinical practice.
   - SPSHU – work informing public health policy, monitoring inequalities, essential to moving public health agenda towards inequalities focus.

   As the research priorities and allocation of funding process to these units had not had much input from our organisation in the past, therefore it would be difficult to say what outputs we would like to see. This point is very pertinent to modernise the CSO funding approach in the future.

3. What sort of engagement would you wish to have with CSO funded units?
   [insert response to this questions here]

   From a future Public Health Scotland this could be formal – e.g. joint/shared posts, honorary contracts, networks, and joint pieces of work/ collaborations and partnerships.

4. What do you consider should be the principal objectives, activities and responsibilities of CSO core funded units, and what should be the advantages, added value and outcomes from this funding?
   [insert response to this questions here]
   Would hope that there is a level of independence from government / policy that would allow them to critically evaluate policies / services. Also not necessarily constrained to short-term political priority work. Long term work plans are essential.

5. Do the current arrangements support both research excellence and the production of research that is responsive to pressing health policy and practice needs or are there disadvantages of this and would different arrangements or alternative models (such as the models set out in the review panel's terms of reference) be more appropriate?
   [insert response to this questions here]

   While there is no question that the CSO funded Units have contributed very considerably, re health research over the years, the model seems historic and anachronistic. It is good time to do this review to modernise the approach. Currently, it seems a "closed shop" in terms of other Groups/Disciplines getting their chance to bid for research infrastructure which should serve over a 5-10 year period rather than for decades with proper on going evaluation/return on investment and impact build in from the outset.

   There are a number of topics and areas which do not benefit as directly from this infrastructure. For example Communicable disease seems like an obvious gap, and HPS and its network of academic partners is a good example that would benefit from some level of continuous infrastructure / funding support. In dental/oral health we previously had the Dental Health Services Research Unit in Dundee but this funding was stopped and dental research is reliant on trying to scrabble for funding from grant funders or uncertain "soft monies" from government.

   Even within the current domain/discipline we should consider building further / additional unit infrastructure / capacity on to what we currently have. For example we need more health economics capacity across public health and health research in addition to HERU. The SPHSU joint funding model with CSO would possibly be good to explore for other areas to bring further funding into play.

   The existing arrangement doesn't promote flexibility and changes in health priorities. A better one would be the NIHR model which is (supposed to be) less fixed and more in tune with the meritocratic and system need ethos.

   Further the Units do not reach out enough to other organisations but that may be due to the intrinsic deficiencies of the model rather than a failure of individuals.

   Given that the themes of the existing units generally concur with work of the establishing Public Health Scotland body, it might be good for the units to be more formally linked with the Public Health Scotland (perhaps in the form of joint posts / honorary contracts). Public Health Scotland could help shape or inform the

strategic direction and work of the units and would helpfully be more arms length than directly from government.

6. What criteria and processes should CSO apply to considerations about continuing, discontinuing and establishing core funded units (or alternative models of research support), including the exit strategy if funding is discontinued?
   [insert response to this questions here]

   The REF assessment of research outputs, environment, and impact would be a good basis. Perhaps with more emphasis on the impact domain and some explicit criteria for Return on Investment.

Strategic review of CSO core funded research units.

Response by : MRC

1. How would you change the current arrangements and why?

We would not wish to change the current arrangements

- Currently, MRC administers the award and leads on the QQR with appropriate and proportional CSO input to the overall review process The current arrangement is rigorous but works smoothly. It means that, despite two funders, the Director work to one set of objectives and metrics for the Unit, which are coherent and consistent
- Regular contact, both formal and informal, is maintained between the CSO and MRC.

2. What outputs have you seen or used from CSO funded units in the past and what health research outputs would you like to see from the units?

- The Unit is a recognised centre of excellence in public health research and is unique in being the only UK Unit able to deliver long-term programmes built around the social determinants of public health.
- In the 2018 CSO strategic review of the SPHSU, the Units engagement and collaboration with policy-makers and the public was highlighted as being highly valued.
- The translation and implementation of the Unit's work beyond Scotland, and more widely to the UK would be highly desirable

3. What sort of engagement would you wish to have with CSO funded units?

The current level of engagement is appropriate and should be maintained

4. What do you consider should be the principal objectives, activities and responsibilities of CSO core funded units, and what should be the advantages, added value and outcomes from this funding?

- The overall Unit objectives are set by the Director and the MRC and the CSO jointly assess the added value and outputs. At the heart of both of our requirements is excellent science based on a long-term strategic vision that justifies the type of funding being provided.
- The added value comes from the long-term core funding of the development of methodology and infrastructure, alongside the bids for external funding for trials for specific interventions based on this new methodology. Added value also comes in the support from the MRC University-Unit partnership model.

5. Do the current arrangements support both research excellence and the production of research that is responsive to pressing health policy and practice needs or are there disadvantages of this and would different arrangements or alternative models (such as the models set out in the review panel's terms of reference) be more appropriate?

- Yes, they currently do. The QQR, which involves eminent researchers and policy-makers from the UK and overseas, ensures that the overall quality, impact and productivity (past and future potential) of the Unit's research programmes and the Unit as a whole is of an internationally competitive standard; that the impact and influence (on policy, practice, and health) is distinctive and important; and addresses MRC and CSO priorities. We also assess whether the Unit model is appropriate to providing the continuity of funding needed to deliver the long-term research programme and the value for money provided by the Unit funding model.

- Clearly the CSO is also supporting the Unit for health benefit in Scotland and MRC for health benefit across the UK and in LMICs, but Scotland can be an ideal test bed for piloting new public health improvement strategies. For example,
    - excellent data linkage of health and other routine data records over a long time period in Scotland, provides a unique opportunity to conduct research in with immediate translational impact of great interest to policymakers outside of Scotland.
    - SPHSU's research looks at context and scalability so that outputs can be relevant beyond Scotland. For example, the Football Fans in Training (FFIT program), which achieved weight loss in Scottish men based on gender sensitivity, has also identified the determinants and mediators of men's long term weight loss in ways to inform which weight management programmes can enhance long term maintenance. This s being applied to contexts outside of Scotland. Other current examples include the evaluation of the prohibition of smoking in prisons and minimum unit pricing (MUP) of alcohol.

STRATEGIC REVIEW OF CSO CORE FUNDED UNITS

UNIT DIRECTOR QUESTIONNAIRE

Response submitted by:

MRC/CSO Social and Public Health Sciences Unit, University of Glasgow (SPHSU)

1. How would you change the current arrangements and why?

Our response to this question is structured under four headings:

A: Overall Objectives of Units:

Currently, there are no overall generic aims and objectives for units, with each unit having its own specific objectives. The briefing attached to this questionnaire states:

"*Currently the objectives set for units are broad and high level, and although the objectives differ between the units, the units all in essence aim to:*

- *Develop and deliver high quality research programmes relevant to improving health in Scotland and to the needs of health and care services;*
- *Foster links with the NHS and Scottish Government and with other research groups and academics;*
- *Develop and apply new research methods;*
- *Make available a body of research expertise and a source of authoritative advice;*
- *Build and sustain research capacity.*"

From SPHSU's perspective, we suggest that it would be helpful to have a generic set of aims and objectives for CSO Units, something along the lines of a generic 'expectations of CSO Units', to include a disaggregated set of generic objectives which could act as a template for unit-specific objectives and provide a consistent framework for the assessment of units. Those outlined in the briefing would appear to be along the right lines, although refinements and additions would be welcome, taking into account the further points raised below. For any specific current or future unit, the unit's own objectives would then need to clearly relate to the overall CSO Unit objectives. In some cases, it may be agreed that a specific unit may not be expected to contribute to all objectives and this could be made explicit and the respective objective(s) not included in the criteria for the assessment of that unit.

Brief comments on the five suggested objectives are as follows:

- *Develop and deliver high quality research programmes relevant to improving health in Scotland and to the needs of health and care services;*

It would be helpful to more explicitly clarify that CSO Units should focus on relatively applied areas of research, something equivalent to NIHR's early phase focus on research that would have an impact on practice within five years, or perhaps NIHR's current focus on research 'with the aim of providing evidence to inform decision making by health and care professionals, NHS managers, patients and the public, and policy makers'. Something along these lines rather than a definition based on later phases of a Cooksey-type translational model. We think something like this is important and consistent with the current objective, and the scope of CSO, but it would be good to clarify that CSO Unit's should not focus on more basic discovery science. The reference to health and care services may also need to be clarified (see B: Scope below).

- *Foster links with the NHS and Scottish Government and with other research groups and academics;*

This should perhaps be split into two (or three) separate objectives:

i) In terms of NHS and Scottish Government, the objective should be stronger, to reflect significant collaboration and partnership, at all stages of the research process, with mature knowledge exchange and coproduction. The units individually and jointly should be a focal point for engagement.
ii) Public and patient involvement should be a further separate objective, critically important for high quality translational research and consistent with Scottish Government policy and principles.
iii) Collaboration with researchers is a separate important dimension (see D: Structure below).

- *Develop and apply new research methods;*

Agreed, usually an important component of innovation and excellence in research.

- *Make available a body of research expertise and a source of authoritative advice;*

This could be clarified. It may relate to expertise and advice for other researchers: a major aim and the largest proportion of CSO funding is to support an excellent research environment in Scotland and it would be welcome to clarify whether CSO Units are expected to explicitly contribute to that aim. In the case of SPHSU, we are very keen to support, as part of the Glasgow Clinical Trials Unit, the Population Health Research Facility (PHRF). The PHRF which supports community based research studies and is a resource available to all researchers, thus contributing explicitly to efficient R&D support for research, through the CSO and additional leveraged funding (from MRC and the University of Glasgow). This objective may also be interpreted as being a source of expertise and advice for decision makers; the 'Foster links…' objective above and this one could perhaps be combined and then more clearly disaggregate the different communities (i.e. other academics; non-academic evidence users; public and patients).

- *Build and sustain research capacity*

It would be good to clarify if this is particularly through training and staff development, or whether there are other aspects of capacity building to which units are expected to contribute (linked to points about collaboration and partnership with non-academic stakeholders and research environment above). Given the withdrawal of CSO non-clinical fellowships and lack of access to NIHR Training and Career Development schemes, at least some of the CSO Units could have an explicit aim of providing early career researcher development opportunities and the creation of future research leaders, a potentially important role for units in Scotland.

<u>B: Scope and Contribution to CSO Strategy:</u>

Much of the current (2015) CSO Health and Social Care Research Strategy is weighted towards NHS-based health care research. It is important to explicitly state the scope of research to be supported by CSO Units, which should include social care and public health – the latter broadly defined to include health impacts of policies in sectors other than health and social care, including transport, the environment, education, social security and justice. The current Public Health Review and imminent creation of Public Health Scotland is, in part, driven by the importance of the recognition of the wider population health system, much of which lies outside Health and Social Care services, for example in Local Authorities or other departments in Scottish Government, and in the Third Sector. A diversity of Scottish Government policy areas and priorities, for example the recent Scottish Public Health

Priorities, Curriculum for Excellence, Inequalities, Active Travel, Climate Emergency have key interdependencies with health research which may potentially be important to include within the scope of one or more CSO Units.

C: Establishment, Review and Renewal:

It is not clear what the process might be to create a new CSO Unit. Is there a fixed budget available for competition? Would such a competition include existing units' renewal being assessed against potential new units? Or restricted to potential new units bidding to an open or commissioned call? Or would it require a strategic process to identify potential need for new unit(s) and a subsequent call?... on a regular or ad hoc basis? Or are there other strategic routes such as potential matched funding for a UK or international priority that may also resonate with needs identified in Scotland? (the only CSO Unit created in the last 15 years (SCPHRP) arose in this way, with joint funding from MRC). It would be useful to clarify this.

As is currently the case, units should be reviewed from both a strategic perspective and a scientific quality/delivery perspective. However, the current process does seem quite inertia driven. Although the CSO has withdrawn core funding from four units over the last 10-15 years (IHR, SCPHRP, DHSRU and RUHBC) it does not seem 'healthy' that the four remaining CSO Units have all been in place for over 20 years with limited major change in their composition over that period. One consideration may be to set the expectation that sole CSO funding for a unit would be for a limited period only (say 10 years) unless (i) there is exceptional demonstration of a continued strategic need; or (ii) co-funding of at least 50% of core funding is in place for any third quinquennium, either in the form of a core funding partnership (as with SCPHRP and SPHSU), or host institution support and/or a financial model based on significant leveraged grant funding. If neither of these conditions were met, then either the CSO core funding would be withdrawn (or reduced/tapered), or if the priority remains, then a competitive process instigated to allow change in the leadership or model of the Unit. An arrangement of this kind would be consistent with MRC's approach to Centre funding, and was applied (by MRC) to their funding of SCPHRP.

Both strategic and scientific reviews should be evidence-based and relate to the agreed CSO Unit objectives, with use of metrics (e.g. based on ResearchFish) and impact case studies to compare returns across units and with alternative forms of investment. As far as we are aware, the track record of CSO Units is strong in terms of standard metrics and delivery has generally been greater than other forms of CSO investment (eg project grant funding). A risk of greater turnover in Unit funding is that the uncertainty and change this introduces will undermine the long term, strategic, programmatic and agile nature of Units, which is a key driver of their excellence and value.

D: Structure of Units:

Units are currently based in single or dual institutions. While it is important that units should demonstrate partnership working, across academic institutions and with local and national policy, health and social care organisations, it is not clear that distributed organisations (such as the NIHR 'School' models for Primary Care and Public Health) are efficient, since there is a high overhead of the regular recommissioning, reconfiguration and project cycle. There may however be a case for greater co-ordination of units and the brokerage of research and collaboration between units and between non-academics and CSO Units. This would potentially increase the visibility and accessibility of units to non-academics, the sharing of resources for engagement, collaboration and communication and other cross-unit synergies.

2. What is the Unit's strategy to help ensure alignment of its research with Scottish Government policy priorities, and important NHS challenges?

SPHSU's core values include:

- working in partnership with decision-makers, professionals and the public;
- maximising the relevance, translation and impact of our work locally, nationally and internationally;

and one of our five scientific objectives is:

- to influence policy and practice by persuasively communicating the results and implications of research to policy, professional and public audiences.

SPHSU has particularly strong links with non-academic public health organisations in Glasgow and Scotland, in strategic long-term collaborations enabled by the Unit's funding model. For example, Moore chairs the Public Health Evidence Network, a collaboration of the SPHSU, NHS Health Scotland, NHS Healthcare Improvement Scotland, Glasgow Centre for Population Health, and the University of Edinburgh; Moore is also a member of the Glasgow Centre for Population Health Management Board; R Mitchell chairs the Scottish Government's "Our Natural Health Service" Research and Evidence Group; Craig chairs the NHS Health Scotland Alcohol Consumption and Harm Evaluation Advisory Group; and SPHSU is one of the member organisations of ScotPHO, the Scottish Public Health Observatory. We have engaged strongly with the Scottish Public Health Reform programme on plans for a research hub, along the lines envisaged by the Academy of Medical Sciences report (*Health of the Public 2040*). We have strong links with the third sector, including ASH Scotland and Alcohol Focus Scotland.

Our model of knowledge exchange, involving strong engagement of policy and practice partners throughout all stages of research, is a cornerstone of our work. All potential new projects are assessed by our Portfolio Group, which requires that, where relevant, non-academic partners are identified as team members from the outset. Collaboration and co-production of research is a key mechanism to ensure the relevance, quality and impact of our research, through the knowledge, networks and influence that the non-academic collaborators contribute to the team. We set aside resources to support response-mode work, providing agility to respond to opportunities that arise from our many planned and serendipitous interactions with non-academics in Scotland. This includes rapid response reviews, evaluability assessment and practice- or policy-led opportunities for evaluation research; two current examples we are involved in evaluating are (i) the prohibition of smoking in prisons and (ii) minimum unit pricing of alcohol. We are active in many Scottish Parliament cross-party groups and routinely respond to consultations and calls for evidence. We organise or contribute to many events and workshops targeted at non-academic audiences and run an in-house policy seminar series, where we invite non-academic speakers to present to us and scope ideas for future collaborations. Our future plans include prioritising the involvement of multiple stakeholders in conceptualising and visualising population health issues using systems mapping techniques and a co-production approach; this will also promote systems thinking among stakeholders and enable us to identify and work with key change agents and networks.

The CSO conducted a strategic review of the SPHSU in 2018, as a first stage in its quinquennial review of the Unit, which feeds into the (second stage) MRC-led scientific review. The strategic review involved consultation with key stakeholders in Scotland, and found universal support for investment in public health research and for the Unit's work. Aspects of the SPHSU's research that were particularly warmly received were the focus on the broader,

upstream determinants of health, on health inequalities, the extent of our collaboration and engagement with non-academics, notably in the evaluation of interventions and policies, and the developing focus on systems and model-based approaches. The strategic review also highlighted the relevance and contribution of the SPHSU's research to Scotland's new *Public Health Priorities* (2018), which place a central focus on reducing health inequalities and include vibrant, healthy and safe places and communities as one of six priorities. The substantial potential for the SPHSU to play a key part in increasing the coordination of public health research in Scotland was identified.

3. How does the Unit support patient and public involvement in research, training, and research capacity building?

As part of our Portfolio Group process, we monitor plans for public involvement in all our projects at the outset. The vast majority of our research is conducted among free-living 'healthy' populations, rather than specific patient groups, and this presents a challenge for public involvement. Our Population Health Research Facility has expertise and networks to facilitate public involvement and we are currently investing, through our ESRC cross-council mental health network (TRIUMPH) in a young people's advisory group to support young-person focused research. The quality of our public involvement has been commended in a number of grant applications to NIHR. SPHSU also has a very strong track record in public engagement, with many of these activities having a component that supports public involvement in our research planning. Public involvement / public engagement is one of the domains assessed in the annual Performance and Development Review of all research staff, and we have regular training events, in addition to University-run courses on public involvement and engagement.

4. What is the added value of CSO's investment in Units?

Particularly relevant to SPHSU, an objectively quantifiable benefit of CSO investment in units is the additional funding that is leveraged into Scotland. The table below indicates research income associated with SPHSU for the period 2015-2020. Over that period, £4m CSO Unit core funding has been critical in leveraging the £19.9m MRC funding and £1.88m University contribution. Additionally, SPHSU researchers have led or been co-Investigators on further research awards totalling £67.85m grant expenditure over the 5-year period, of which £9.78m has been income to SPHSU. A total of £38.97m research income (core and grant combined) has been won from funders outside Scotland for SPHSU's core-funding and for projects involving collaboration between SPHSU and other investigators based in Scotland. A major aim of CSO is to increase research grant income into Scotland, notably through contributing to certain NIHR funding mechanisms and supporting Scotland's research environment; CSO Units also make a very strong contribution to this aim, as exemplified by SPHSU.

CSO Units are focused on areas of strategic need and further added value might be the multiplier effect of leveraged institutional, core and grant funding being particularly directed into these priority areas. Other important areas of added value from CSO Units include training and staff development in priority areas, the development of 'soft' infrastructure – collaborations, partnerships and networks – and key focal points of research support and expertise; these would not arise at scale from other shorter term funding mechanisms. Unit's are also able to be agile and responsive to the research needs of stakeholders in ways that are not possible when all resources are tied up in the delivery of short term projects. Units contribute to Scotland's excellent research infrastructure and to Scotland's international reputation.

SPHSU Income 2015-2020 Source	No. of awards	Value of award income to SPHSU	Total value of awards	Value of awards with Co-Is in Scotland**
CSO	8	£779,408	£1,415,011	£1,415,011
Scottish government	14	£364,857	£6,873,830	£6,873,830
NIHR	20	£3,600,694	£17,831,631	£7,942,627
UKRI/ RCUK	30	£3,061,010	£30,522,433	£9,947,562
Charity	20	£1,418,071	£9,431,855	£2,225,933
Other	28	£559,903	£1,775,578	£958,584
Total external awards	**120**	**£9,783,943**	**£67,850,338**	**£29,363,547**
CSO core funding		£4,000,000	£4,000,000	£4,000,000
MRC core funding		£15,700,000	£15,700,000	£15,700,000
MRC infrastructure supplement		£2,200,000	£2,200,000	£2,200,000
UofG contributions*		£1,883,000	£1,883,000	£1,883,000
Total into Scotland				**£38,974,706**
Total		£33,566,943	£91,633,338	**£53,146,547**

* includes studentship fees and stipend, the funding of fellowships and REF income
** Some awards also involve Co-Is outside Scotland so not all of this income comes to Scotland
Source: University of Glasgow research database, actuals to 2018/9, forecasts for 2019/20.

5. Do the current Unit funding arrangements support both research excellence and the production of research that is responsive to pressing health policy and practice needs or would different arrangements be more appropriate?

Units focussed on priority areas of applied health and social care research are an excellent mechanism to combine both research excellence with responsive, relevant and impactful research outcomes and support. The funding model of Units, subject to both strategic and scientific reviews and contributing to their host institutions' REF returns, incentivises both scientific excellence and research that meets the needs of decision-makers.

Comparing Scotland to England, we do not have NIHR's Biomedical Research Units and Centres (£6-114m), CLAHRCs (£10m+), Policy Research Units (£5M+) or Schools (c.£20m), or NIHR Programme Grants. There is a lot of ground to cover in terms of infrastructural investment to support applied health research and its translation into policy and practice. The CLAHRCs and Schools probably cover the ground where CSO focus Unit funding, high quality translational research relevant to regional / national priorities involving academic and non-academic partners. The Policy Research Units are strong in England but probably too applied/responsive to be the focus of the very restricted funding available in Scotland (eg. they would be less likely to secure substantial leveraged funding) and the distributed School model may be less efficient than a Unit with strong leadership from a single institution.

Units are not required to follow any specific governance model and it may be a worthwhile consideration for CSO Units to have mandatory Advisory Boards, with representatives from other HEIs and from key NHS and Scottish Government departments to ensure strategic priorities are to the fore. These Advisory Boards would need to be appointed by CSO with rotating membership, and could also have a role in unit reviews. For example, they could conduct mid-term reviews and be part of quinquennial reviews.